DRAFT

Guidelines for Facility Coding of Evaluation and Management (E/M) Services

Comments

CMS requested comments on guidelines for facility coding of E/M visits in the August 24, 2001 OPPS Proposed Rule. In this rule we also stated that the comments received would be forwarded to the APC Technical Panel for recommendations and that after receiving the panel's recommendations we would propose Coding Guidelines for Emergency Department and clinic visits in the OPPS proposed rule for 2003. CMS intends to follow through with this plan.

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Several commenters stated that CPT reporting criteria and current E/M documentation guidelines for physicians are not appropriate for use by facilities for Emergency Department and clinic visits, because they do not reflect facility resource utilization. Commenters also raised concerns about being cited for compliance and audit issues and for variations among facilities in coding for these visits. These commenters requested that facility-coding guidelines be developed that are in compliance with HIPAA.

Several commenters recommended the adoption of specific guidelines for facility coding of E/M services: These are summarized below:

- The American Hospital Association and the American Health Information Management Association recommended adoption of the facility coding guidelines for emergency department visits developed by the American College of Emergency Physicians.

- Several hospitals recommended the use of staff contact time as the primary determinant for coding emergency and clinic visits.

- The Federation of American Hospitals (FAHA), several wound care centers, and several hospital consultants recommended use of a point system to determine the level of service.

- Other recommendations included use of diagnosis to determine the level of service, and a hybrid approach using medical decision making and staff contact time to determine the level of service.

We also received comments asking us not to develop guidelines based upon the belief that a new facility based system would burden hospitals and physicians and would not reflect resource utilization.

CMS Response to Comments

CMS concurs with commenters that separate coding guidelines for emergency department and clinic visits should be established as soon as possible. This system would assist CMS in making appropriate payments based on resource utilization. Since this system would not directly measure physician activities, we disagree with the commenters who stated that this system would impinge upon medical practice.

CMS recognizes and supports the need to have input from providers to assure that those guidelines accurately and adequately describe facility resource use and facilitate accurate coding of services. We also acknowledge the complexity in identifying and establishing guidelines that reflect work performed by Emergency Department and clinic staff; other resource consumption; and the diversity of patients' needs and conditions;

The following represents CMS' current thoughts on facility guidelines for emergency and clinic visits. We have included a draft of options for facility coding of clinic and emergency visits. These options were developed after careful review of comments.

Assumptions

CMS has developed the following list of assumptions that were used as the basis for formulating the options described below.

1. Facility Coding for emergency department and clinic visits should only reflect use of resources by those departments. For example, if institutional practice is for personnel from the radiology department to prepare and/or transport a patient, it is expected that the expenditure of those resources would be accounted for in the payment for radiology services.

2. Facility Coding for emergency department and clinic visits may not be similar to physician coding for the same service because resource utilization may not directly correlate with physician activities.

3. Facility Coding for emergency department and for clinic visits should be uniform across all facilities, be reproducible, and should result in a normal (non-skewed) distribution of services reflecting the care provided.

4. Guidelines for Facility Coding of E/M services for Emergency Department and clinic visits should be simple, supported by the medical record, represent the clinical care provided without necessitating duplication of documentation, and allow for easy assignment by a coder to the chargemaster.

5. Guidelines for Facility Coding of E/M services should be usable for compliance purposes, audits, and for meeting HIPAA requirements.

6. The guidelines must allow identification of the resources used in providing an E/M service and separation of those resources from the resources used to provide other services (e. g. laceration repair, sigmoidoscopy, skin lesion removal etc.) to the same beneficiary on the same date.

7. Guidelines should encourage workplace efficiency and the use of appropriate staff level to perform requisite care. It is CMS' intent that staff types used and time spent performing interventions in the emergency department or clinic be supported by established standards of care and that this be reflected in payments for these services.

8. Because of differences in resource consumption and utilization, separate guidelines should be developed for emergency department and for clinic visits.

9. All options assume that coding for patients requiring continuous nursing care in the emergency department or clinic, admission, or transfer to another facility for a higher level of care would utilize codes consistent with the guidelines. In addition activities that would justify the use of CPT code #99291 (APC 620) are not included in the options because 99291 is a time based code.

10. Certain activities were not counted as interventions provided by staff in the emergency department or clinic because they do not consume separately identifiable resources or because other departments or services provide them. Examples of these activities include:

    a. Obtaining U/A when patient provides the specimen
    b. Paging physicians. It is assumed that the clerical function of calling a physician would not be identified as an intervention. However, if there were a need for Emergency Department and/or clinic staff to obtain orders or to engage in consultative dialogue, the activity would be considered an intervention.
    c. Case management/social services activities. It is assumed that staff members from a cost center other than the emergency department or clinic provide this service. However, if Case Management/Social Service activity is performed by an Emergency Department or clinic staff member, e. g. obtaining shelter placement for a homeless individual, that activity would be considered an intervention.
    d. Obtaining blood laboratory specimens after starting an IV. It is assumed that blood specimens are obtained when an IV line is started, therefore obtaining the specimens would not be considered a separate intervention. However, if it were medically necessary to perform an additional venipuncture, this would be considered an intervention separate from starting the IV.

Issues To Be Resolved

CMS recognizes that there are substantive issues remaining to be addressed during the development of facility coding guidelines. These unresolved issues include:

1. What is the validity of the standards currently being used by hospitals to report E/M services?

2. Is it possible for facilities to cleanly and clearly separate resources used for E/M services from resources used for other services (e. g. laceration repair)?

3. What currently available facility data will facilitate guideline development? (e. g. nursing time or interventions per patient) If no such data is available will facilities be able to develop a process to make them available?

4. Should CMS develop guidelines for five levels of clinic and ER visits (e. g. 99281, 99282, 99283, 99284,and 99285) that reflect CPT codes? Or should CMS develop guidelines for three levels of clinic and ER visits (e. g. low, mid, and high-level visits) that reflect the APC structure? If CMS develops guidelines for three levels of service what, if anything, should CMS instruct hospitals to do with regard to differentiating visits within an APC (e. g. 99281 from 99282)?

5. Will facility coding guidelines promote work efficiencies, the performance of only necessary interventions, and the use of appropriate staff?

Options for Emergency Department Visits

The following represent CMS' thoughts on various guidelines that might be used for standardizing facility coding of emergency department visits. A discussion follows each section. CPT codes currently used for Emergency Department facility charges have been included.

1. Guidelines based on staff interventions

The following options are based on the number of staff interventions.

A. Five Levels of Care

The baseline level of care includes registration, triage, initial nursing assessment and periodic vital signs (as appropriate). It also includes 1 limited intervention which utilizes minimal resources (e. g. administration of an oral medication, obtaining blood for a CBC, visual acuity determination, rapid strep), discharge instructions, and exam room set up/clean up.

Additional interventions exceeding the base level of care include activities such as extended initial nursing assessments; extended nursing discharge instructions and arrangements; patient care activities (e. g. preparing the patient for diagnostic tests, starting IVs, administering medications, changing dressings, assisting the physician during an exam, NG tube or Foley catheter placement), and patient education/support activities (e. g. contacting physicians for orders).

Level I: (CPT 99281) – Baseline level of care.

Level II: (CPT 99282) – Includes baseline level of care plus a minimum of 2 additional interventions.

Level III: (CPT 99283) – Includes baseline level of care plus 3 or 4 additional interventions.

Level IV: (CPT 99284)– Includes baseline level of care plus 5 or 6 additional interventions.

Level V: (CPT 99285) – Includes baseline level of care plus 7 or more additional interventions. This level includes care for patients requiring admission, transfer to another facility, or who expire in the emergency department after receiving extensive care. It does not include patients who are transferred or expire after receiving critical care interventions (e. g. sixty minutes of continuous cardiopulmonary resuscitation).

Discussion:

This option emphasizes quantification of activities with reimbursement directly related to the number of interventions provided at each encounter. The length of time, acuity of patient, numbers of staff required per intervention and diagnosis are not the driving factors for determining the level of care. However, theoretically the greater number of requisite interventions would correlate with a greater length of time in the ED and reflect higher acuity level.

B. Three Levels of Care:

The baseline level of care includes registration, triage, initial nursing assessment and periodic vital signs (as appropriate). It also includes 1 limited intervention which utilizes minimal resources (e.g. administration of an oral medication, obtaining blood for CBC, visual acuity, rapid strep), discharge instructions, and exam room set up/clean up.

Additional interventions exceeding the base level of care include activities such as extended initial nursing assessments; extended nursing discharge instructions and arrangements; patient care activities (e. g. preparing the patient for diagnostic tests, starting IVs, administering medications, changing dressings, assisting the physician during an exam, NG tube or Foley catheter placement), and patient education/support activities (e. g. contacting physicians for orders).

Level I: (CPT 99281 or 99282): Low Level Emergency Department Visits: Base level of care plus 2 additional intervention.

Level II: (CPT 99283). Mid Level Emergency Department Visits: Includes base level of care plus 3 or 4 additional interventions.

Level III: (CPT 99284 or 99285) High Level Emergency Department Visits: Includes base level of care plus 5 or more additional interventions.

Discussion:

Comments described above for 5 levels of care would also apply in this option, except the need to differentiate care would be compressed into three levels. Determination of the appropriate CPT code to use for Levels I & II would be required.

2. Guidelines based on Staff Time:

The following options utilize time as a measurement to determine levels of care .

A. Five Levels of Care

The baseline level of care includes registration, initial nursing assessment and periodic vital signs (as appropriate), discharge instructions, and exam room set up/clean up. Limited interventions, utilizing minimal resources and requiring 10 minutes or less of additional staff contact (e. g. administration of an oral medication, obtaining blood for CBC, visual acuity, rapid strep) are included in the base level of care.

Additional time exceeding the baseline level of care includes time spent performing activities such as extended initial nursing assessments; extended nursing discharge instructions and arrangements; patient care activities (e. g. preparing the patient for diagnostic tests, starting IVs, administering medications, changing dressings, assisting the physician during an exam, NG tube or Foley catheter placement); and patient education/support activities (e. g. contacting physicians for orders).

Level I: (CPT 99281) – Baseline level of care and up to 10 minutes of additional staff contact

Level II: (CPT 99282) – Includes baseline level of care plus 11-20 minutes of additional staff contact.

Level III: (CPT 99283) – Includes baseline level of care plus 21 - 45 minutes of additional staff contact.

Level IV: (CPT 99284) – Includes baseline level of care plus 46 - 60 minutes of additional staff contact.

Level V: (CPT99285) – Includes baseline level of care plus 60 or more minutes of additional staff contact. This level includes care for patients requiring admission, transfer to another facility, or who expire in the emergency department. It excludes those patients who are transferred or who expire after receiving Critical Care interventions.

Discussion:

This option emphasizes quantification of time and reimbursement is directly related to the number of staff minutes spent in direct contact with the patient. The type or number of interventions, acuity of patient, numbers of staff required per intervention and diagnosis are not the driving factors for determining the level of care. However, theoretically the greater length of time required would correlate with a higher acuity level.

Identification of standard times for performing activities would be required to assure that unrealistic expectations for completion of interventions or that "time creep" does not occur.

B. Three Levels of Care:

The baseline level of care includes registration, initial nursing assessment and periodic vital signs (as appropriate), discharge instructions, and exam room set up/clean up. Limited interventions, utilizing minimal resources and requiring 10 minutes or less of additional staff contact (e.g. administration of an oral medication, obtaining blood for CBC, visual acuity, rapid strep) are included in the base level of care.

Additional time exceeding the baseline level of care includes time spent performing activities such as extended initial nursing assessments; extended nursing discharge instructions and arrangements; patient care activities (e. g. preparing the patient for diagnostic tests, starting IVs, administering medications, changing dressings, assisting the physician during an exam, NG tube or Foley catheter placement); and patient education/support activities (e. g. contacting physicians for orders).

Level I: (CPT 99281 or 99282) Low Level Emergency Department Visits: Base level of care plus up to 20 additional minutes of staff contact.

Level II: (CPT 99283) Mid Level Emergency Department Visits: Includes base Level of Care plus 21-45 minutes of additional staff contact.

Level III: (CPT 99284 or 99285) High Level Emergency Department Visits: Includes base Level of Care plus more than 46 minutes of additional staff contact.

Discussion:

Comments described above in the 5 levels of care would also apply in this option, except the need to differentiate care would be compressed into three levels. Determination of the appropriate CPT code to use for Levels I & II would be required.

3. Guidelines based on a "point" system

In this option, points are applied to different interventions with the resulting total of points equating to the level of care. To illustrate the options using points we created a list of clinical interventions and assigned points to each intervention. The number of points assigned is meant to be a starting point for discussion only.

The baseline level of care includes registration, triage, initial nursing assessment and periodic vital signs (as appropriate). It also includes 1 limited intervention which utilizes minimal resources (e.g. administration of an oral medication, obtaining blood for CBC, visual acuity, rapid strep), discharge instructions, and exam room set up/clean up. These activities are equivalent to "Zero" (0) points.

Additional interventions exceeding the baseline level of care include activities such as extended initial nursing assessments; extended nursing discharge instructions and arrangements; patient care activities (e. g. preparing the patient for diagnostic tests, starting IVs, administering medications, changing dressings, assisting the physician during an exam, NG tube or Foley catheter placement), and patient education/support activities (e. g. contacting physicians for orders). Points are essentially "add-ons" that are totaled to achieve a final score. "Points" are applied to interventions provided by emergency room staffs that are additional to the baseline activities.

Intervention	Points
Extended Triage	2 points
Extended Initial Nursing Assessment	3 points
Extended Nursing Discharge	3 points
Nursing Reassessment (-excluding vital signs -) – each	3 points
Starting IV (with or without lab tests)	3 points
Other lab tests, obtaining specimen (each)	1 point
EKG – each	1 point
Patient transport (non RN)	2 points
Accompany & remaining with patient to radiology, CT etc (RN)	7 points
Continuous Monitoring - each (e. g. pulse ox-, cardiac monitor)	1 point
Insertion of tubes - each (e.g. NG, Foley)	4 points
Administration of medications – oral –	1 points
Administration of medications– each -IV, IM, suppository, SC	2 points
Initiation of Oxygen therapy	1 point
Wound Care/Dressings (only if NOT separately Billable with another CPT code) – simple	1 point

- complex	3 points
Assisting physician with complex exam or procedure (only if NOT separately billable with another CPT code)	5 points
Chaperone exam or minimal assist	2 points
Other interventions – only if requiring more than 10 minutes of staff time	3 points
Restraint application	4 points
Patient/family Education - simple	1 point
Patient Education – complex	3 points
Consultation with other physicians/departments	1 point
Blood product administration – each unit	2 points

Determination of Level – Scoring

A. Option A:

Level 1: (CPT 99281)	Points - 0–10
Level II: (CPT 99282)	Points – 11-20
Level III: (CPT 99283)	Points - 21-30
Level IV: (CPT 99284)	Points – 31-40
Level V: (CPT 99285)	Points – 41 or more

Discussion:

This option emphasizes quantification of interventions and time with reimbursement directly related to the number of minutes spent in direct contact with the patient and to the level of complexity of the intervention. The acuity of patient, numbers of staff required per intervention and diagnoses do not determine the level of care. The difficulties inherent in this option are determining the appropriate numbers of points for each intervention. This system integrates time and complexity of interventions and should correlate with a patient's acuity level. Because the point allocation per intervention depends on both the complexity of the intervention and the length of time devoted to the patient, the number of points should also correlate with a patient's acuity level.

B. Option B:

Level I: (CPT 99281 or 99282) - Low Level ED Visits	Points – 0-20
Level II (CPT 99283)- Mid Level ED Visits	Points – 21-30
Level III (CPT 99284 or 99285)- High Level ED Visits	Points – 31 or more

Discussion:

Comments described above in the 5 levels of care would also apply in this option, except the need to differentiate care would be compressed into three levels. Determination of the appropriate CPT code to use for Levels I & II would be required.

Other Options

We reviewed other suggestions and determined that the following could not be effectively implemented. CMS believes that any approach using diagnoses or medical decision making is too complicated, will be burdensome for hospitals, and will not result in standardization of code assignment

1. **Presenting Symptoms** – This would require assignment of CPT level to each ICD-9 CM code. It remains unclear how this would be done and whether such a crosswalk would be hospital specific or standardized across hospitals. The crosswalk would require taking into account co-morbidities and final diagnoses. It would also require being updated on a regular basis to reflect changes in ICD-9 codes.

2. **Final diagnoses** – Because the length and interventions of ED visits are based on presenting problems prior to the determination of a final diagnosis, it is unclear how such a system could accurately reflect facility resource use.

3. **Level of medical decision-making** - Similar problems as described for "Presenting Symptoms." In addition, since facility coding is distinct from physician intervention, it is unclear how resource utilization would be equated to medical decision-making.

4. **Combination of Diagnoses and Time** - Similar problems as described for use of "Presenting Symptoms" and "Final Diagnosis" as guidelines.

Clinic Visits

Based on comments and other information received by CMS, we believe that clinic visits warrant different guidelines from emergency department visits because of the differences in use of hospital resources. However CMS has not received any comments or evidence indicating that development of separate guidelines for new patient visits, established patient visits or consultations is warranted.

CMS believes that guidelines for 3 levels of care (consistent with the APC structure) will reflect the resources used in clinic visits. The following demonstrates incorporation of the 3 options used above for Emergency Department E/M guidelines.

1. Guidelines based on staff interventions

The baseline level of care includes registration, triage, initial nursing assessment and periodic vital signs (as appropriate). It also includes 1 limited intervention which utilizes

minimal resources (e.g. administration of an oral medication, obtaining blood for CBC, visual acuity, rapid strep), discharge instructions, and exam room set up/clean up.

Additional interventions exceeding the baseline level of care include activities such as extended initial nursing assessments for new patients; extended nursing discharge instructions and arrangements; patient care activities (e. g. preparing the patient for diagnostic tests, starting IVs, administering medications, changing dressings, assisting the physician during an exam, NG tube or Foley catheter placement), and patient education/support activities (e. g. contacting physicians for orders).

Level I: (Level 1 or 2 visits): Low Level Clinic Visits – Includes baseline level of care plus two additional interventions.

Level II: (Level 3 visits): Mid Level Clinic Visits – Includes baseline plus three additional interventions.

Level III: (Level 4 or 5 visits): High Level Clinic Visits – Includes baseline plus four or more additional interventions.

Discussion:

This option emphasizes quantification of activities with reimbursement directly related to the number of interventions provided at each encounter. The length of time, acuity of patient, numbers of staff required per intervention and diagnosis are not the driving factors for determining the level of care. However, theoretically the greater number of requisite interventions would correlate with greater length of time in the clinic and would reflect clinic resource consumption. Determination of the appropriate CPT code to use for Levels I & II would be required.

2. **Guidelines based on staff time**

The baseline level of care includes registration, initial nursing assessment and periodic vital signs (as appropriate), discharge instructions, and exam room set up/clean up. Limited interventions, utilizing minimal resources and requiring 15 minutes or less of additional staff contact (e.g. administration of an oral medication, obtaining blood for CBC, visual acuity, rapid strep) are included in the base level of care.

Additional time exceeding the baseline level of care includes time spent performing activities such as extended initial nursing assessments; extended nursing discharge instructions and arrangements; patient care activities (e. g. preparing the patient for diagnostic tests, starting IVs, administering medications, changing dressings, assisting the physician during an exam, NG tube or Foley catheter placement); and patient education/support activities (e. g. contacting physicians for orders).

Level I: (Level 1 or 2 visits) Low Level Clinic Visit: Includes base level of care and up to 25 minutes of additional staff contact..

Level II: (Level 3 visits) Mid Level Clinic Visit: Includes base level of care plus 26-45 minutes of additional staff contact.

Level III: (Level 4 or 5 visits) High Level Clinic Visit: Includes base level of care plus more than 45 minutes of staff contact.

Discussion:

This option emphasizes quantification of time with reimbursement directly related to the number of minutes spent in direct contact with the patient. The type or number of interventions, acuity of patient, numbers of staff required per intervention and diagnosis are not the driving factors for determining the level of care. However, theoretically the greater length of time required would correlate with a higher acuity level.

Identification of standard times for performing activities would be required to assure that unrealistic expectations for completion of interventions or that "time creep" does not occur.

2. Guidelines based on a "point" system

In this option, points are applied to different interventions with the resulting total of points equating to the level of care. To illustrate the options using points we created a list of clinical interventions and assigned points to each intervention. The number of points assigned is meant to be a starting point for discussion only.

The baseline level of care includes registration, triage, initial nursing assessment and periodic vital signs (as appropriate). It also includes 1 limited intervention which utilizes minimal resources (e.g. administration of an oral medication, obtaining blood for CBC, visual acuity, rapid strep), discharge instructions, and exam room set up/clean up. These activities are equivalent to "Zero" (0) points.

Additional interventions exceeding the baseline level of care include activities such as extended initial nursing assessments; extended nursing discharge instructions and arrangements; patient care activities (e. g. preparing the patient for diagnostic tests, starting IVs, administering medications, changing dressings, assisting the physician during an exam, NG tube or Foley catheter placement), and patient education/support activities (e. g. contacting physicians for orders). Points are essentially "add-ons" that are totaled to achieve a final score. "Points" are applied to interventions provided by clinic staffs that are additional to the baseline activities.

Intervention	Points
Extended Initial Assessment – new patient	3 points
Extended Nursing Discharge	3 points
Nursing Reassessment (-excluding vital signs -) – each	3 points
Starting IV (with or without lab tests)	3 points
Other lab tests, obtaining specimen (each)	1 point
EKG – each	1 point
Patient transport (non RN)	2 points
Continuous Monitoring - each (e. g. pulse ox-, cardiac monitor)	1 point
Insertion of tubes - each (e.g. NG, Foley)	4 points
Administration of medications – oral –	1 points
Administration of medications– each -IV, IM, suppository, SC	2 points
Initiation of Oxygen therapy	1 point
Wound Care/Dressings (only if NOT separately Billable with another CPT code) – simple	1 point
- complex	3 points
Assisting physician with complex exam or procedure (only if NOT separately billable with another CPT code)5 points	
Chaperone exam or minimal assist	2 points
Other interventions – only if requiring more than 10 minutes of staff time	3 points
Restraint application	4 points
Patient/family Education - simple	1 point
Patient Education – complex	3 points
Consultation with other physicians/departments	1 point
Blood Product Administration – each	2 points
Chemotherapy administration	2 points

Determination of Level – Scoring

Level 1- (Level 1 or 2 visits): Low Level Clinic Visit	0-20 Points
Level II - (Level 3 visits): Mid Level Clinic Visit	21-30 Points
Level III - (Level 4 or 5 visits): High Level ED Visits	31 or more Points

Discussion:

This option emphasizes quantification of interventions and time with reimbursement directly related to the number of minutes spent in direct contact with the patient and to the level of complexity of the intervention. The acuity of patient, numbers of staff required per intervention and diagnoses do not determine the level of care. The difficulties inherent in this option are determining the appropriate numbers of points for each intervention. This system integrates time and complexity of interventions and

should correlate with a patient's acuity level. Because the point allocation per intervention depends on both the complexity of the intervention and the length of time devoted to the patient, the number of points should also correlate with a patient's acuity level.

Other types of guidelines –

For the same reasons set forth above for emergency department visits, CMS does not believe that guidelines based in any way on diagnoses or medical decision making are appropriate for clinic visits.

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